SWALLOWING DISORDERS
FOLLOW-UP ASSESSMENT

See instructions on reverse side of this page.

Name: _____ **Residence:** _____ **DOB:** _____

Has this person been diagnosed with/have or have history of any of the following?

_____ Confirmed aspiration
_____ @ risk of aspiration
_____ GERD
_____ Dysphagia
_____ Decreased esophageal motility
_____ Hiatal Hernia
_____ S/P Nissen Fundoplication
Other: _____

Does this person take any of these medications? If yes, please give dosage, time given & date initiated.

Reglan _____
Prevacid _____
Zantac _____
Other: _____
Pepcid _____
Prilosec _____
Nexium _____

Current diet consistency: _____
Does this person take nutritional supplements? If so, list the supplement and when given.
_____
_____**Independent or** _____**Dependent feeder ? Adaptive Dining equipment :** _____

12 MONTH HISTORY: (DATES & RESULTS)

List weight history/date for the past 12 mos and corresponding diet orders changes: **IWR**_____

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

URIs: _____ **Pneumonias**: _____ **Hospitalizations**:_____
(dates) _____ (dates) _____ (dates) _____
_____ _____ _____

COMMENTS regarding above: (i.e. tx method/medications, etc.)_____
_____
_____

Chest x-rays dates/results: _____
_____
Hgb/range/date : _____ **Albumin/range/date :** _____

DIAGNOSTIC TESTING RESULTS: ATTACH ALL RESULTS

Modified Barium Swallow study (MBS)/date: _____
_____
_____
Esophagram/ Barium Swallow/date: _____
Upper Gastrointestinal series (UGI)/date: _____
Esophagogastroduodenoscopy (EGD)/date: _____
Gastroenterology Referral(s)/date: _____
OT/ST Evaluations/ date: _____
Comments: _____

Person completing assessment:_____ **Date:** _____
RETURN Mailing address: _____
Email: _____**Date sent to Vivian Koon:** _____ **(see pg.2 for address/fax)**

SWALLOWING DISORDERS FOLLOW UP ASSESSMENT
INSTRUCTIONS FOR COMPLETING

Please complete ALL information requested on assessment. Assistance from someone with medical training or expertise may be needed.

Diagnoses: Check all confirmed diagnoses. Put "?" if questionable diagnosis and "Hx" if there is a past history of a specific diagnosis. Also list any other diagnoses pertinent to Dysphagia (disorders in the swallowing process which result in some degree of dysfunction of eating and swallowing) or Gastroesophageal Reflux Disease (GERD) (the backflow of gastric or duodenal contents, or both into the esophagus).

Medications: Check if this person receives any of the listed medications. If so, list dosage. List any other medications related to GERD or Dysphagia including any psychotropic /behavioral medications that could be given for vomiting, regurgitation, rumination, etc. Also list any medications with known side effects of difficulty with swallowing, nausea, digestion, etc.

Current diet consistency: document current diet/liquids consistency orders
Nutritional supplements: List any supplements person receives (e.g., Ensure, 2 Cal Hn, High Cal Pudding). Document if supplements are with meals, between meals, etc.
Independent or Dependent Feeder? Adaptive dining equipment?
Weight Concerns in last 12 months: Document any weight fluctuations, change in caloric intake or any concerns regarding the consumer's weight in the past 12 months.

URI = Upper Respiratory Infections: Document any upper respiratory infections in the last 12 months, dates and treatment.
Pneumonia: Document any episodes of pneumonia in the past 12 months, dates and treatment.
Hospitalizations: Document any hospitalizations in the past 12 months, dates, reason and treatment.
Please make any comments regarding any URI, Pneumonias or Hospitalizations listed.

CXR/results: Document any CXRs performed in the past 12 months, dates and results.
Hgb/range/date: Document any **Hemoglobin** results, range and date drawn in past 12 mos.
Albumin/range/date: Document any **Albumin** results, range and date drawn in past 12 mos.

Diagnostic Testing: ATTACH results from requested diagnostic testing/MD visits in the past 12 months
Modified Barium Swallow Study Results (MBS): Document any previous swallow studies performed, date, facility where study was performed and results.
Esophagram/Barium Swallow (BS): Document any previous esophagram study, date, facility where performed and results.
UGI series: Document any previous UGI study, date, facility where performed and results.
EGD: Document any previous EGD study, date, facility where performed and results.
GI referral(s): Document any previous GI referrals, date, MD and recommendations.
OT/ ST evaluations: Please list dates and attach copies of any OT/ST evals in last 12 months.
Comments: Document any further information that may be appropriate for assessing current status.

This Assessment must be attached to the Swallowing Disorders Checklist and be sent to:
Vivian Koon Director, Office of Health Services Phone: 864-938-3509
By Fax: 864-938-3179
By mail: PO Drawer 239, Clinton, SC 29325